CANADA
Province of Alberta

Report to the Minister of Justice and Solicitor General Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Edmonton Law Courts

in the City (City, Town or Village) of Edmonton (Name of City, Town, Village), in the Province of Alberta,

on the 2nd, 3rd and 4th day of November, 2016 (year), (and by adjournment

on the 21st day of March, 2017 (year)),

before Greg Lepp, a Provincial Court Judge,

into the death of Dani Isabella Jean (Name in Full) 6 weeks (Age)

of Edmonton (Residence) and the following findings were made:

Date and Time of Death: Pronounced at 6:22 AM on May 4, 2013

Place: Edmonton, Alberta

Medical Cause of Death:
Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – The Fatality Inquires Act, Section 1(d)).

Undetermined

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, suicidal, accidental, unclassifiable or undeterminable – The Fatality Inquiries Act, Section 1(h)).

Undetermined

FOREWORD:
In compliance with the *Child, Youth and Family Enhancement Act*, a second foster child in the Martin's home is referred to as "S" in this report.

Circumstances under which Death occurred:

1. Parties Participating in the Inquiry

Inquiry Counsel: Alberta Justice and Solicitor General - Nicole Pfeifer
Alberta Human Services – William Hogle, QC
Crossroads Family Services – Dino Bottos
Cheraty and Eric Martin, Foster Parents – Dino Bottos
Kuna Sauvé, Biological Mother – self-represented
Paul Jean, Biological Father – self-represented

2. Witnesses Called

Cheraty Martin – Foster Mother
Eric Martin – Foster Father
Matthew Gates - Emergency Medical Services, Alberta Health Services
André Hiller – Constable, Edmonton Police Service
Shannon Edsas (previously Shannon Hastings) – Caseworker, Alberta Human Services
Arleen Hollinger – Case Work Supervisor, Alberta Human Services
Rebecca Lima (previously Rebecca Countaway) – Foster Care Support Worker, Crossroads Family Services
Elaine Roemmich – Program Director, Crossroads Family Services
Angela Ross – Program Consultant, Alberta Human Services
Bernard Bannach – Medical Examiner, Office of the Chief Medical Examiner

3. Introduction

Dani Isabella Jean, ("Dani"), a six week old infant, was found dead in the bed of her foster parents, Cheraty and Eric Martin at about 5:30 AM on May 4, 2013. The undisputed evidence establishes that she died of undetermined causes. This Public Fatality Inquiry was ordered on the recommendation of the Fatality Review Board. The Board believed that recommendations could potentially be made to prevent similar deaths[i].

In this report, I will first set out the factors that research has shown may increase the risk of unexplained deaths in infants. I will then explain why only one issue exists in this case relevant to the said factors, that issue being potential bed sharing with adults. Following that, I will review the chronology of events surrounding Dani's death. Finally, I will analyze those events to explain why I have concluded that no bed sharing took place in this case.

4. Undetermined Death

Dr. Bernard Bannach, the forensic pathologist in this case, concluded that the cause of Dani's death was undetermined. This means that, following a complete autopsy, there were no natural diseases, metabolic processes or traumatic injuries that could have led to her death. There was also nothing in her clinical history or in the known circumstances that existed at the time explaining why she died. In the past, when an infant died under these circumstances, medical examiners in Canada and elsewhere used the term SIDS (Sudden Infant Death Syndrome) but that term has fallen out of use. Now the term *Sudden Unexplained Death of an Infant* ("SUDI") is more commonly used but Dr. Bannach testified that it is not considered helpful in the pathologist community to differentiate unexplained death by age.

Fewer than one in a thousand infants in Alberta die in circumstances where the cause is undetermined.[ii] Even though these deaths are rare, more infants die in unexplained circumstances than by any other single identifiable cause. By definition, of course, there is no discernable cause for unexplained infant death, but certain factors have been shown to increase the risk that an otherwise healthy infant will die in this way:

- Sex – boys are more likely to die than girls;
- Age – infants are most vulnerable during the second or third month of life;
- Race – Research in the US has shown that, in that country, African American and Indigenous infants are more likely to die;
- Family History- if his or her siblings or cousins died in unexplained circumstances it is more likely that an infant will also die;
- Secondhand smoke – presence of secondhand smoke in the home has been associated with increased risk;
- Length of Gestation: - premature babies are more at risk;
- Recent respiratory infections including colds;
- Bed sharing with adults – this increases risk especially where alcohol or drugs have been consumed;
- Sleeping surfaces – an infant sleeping on a soft surface or with soft blankets or toys is at increased risk;
- Sleep position – putting the infant to sleep on his or her back is the safest.[iii]

Certain practices have been shown to reduce the risk:

- Breast-feeding at least for the first six months;
- Co-sleeping with adults in the same room but in a separate crib;
- Offering a pacifier.

5. Key Issue: Potential Bed Sharing

During my description of the circumstances of Dani's death and in addressing the issues that arose during this Inquiry relating to those circumstances, I must keep top of mind the risk factors listed above because the main reason for holding a Fatality Inquiry is to determine whether there are recommendations that can be made to reduce the risk of future death. I have concluded that the only potential avoidable risk factor raised in this case is bed sharing. The key issue in this Inquiry is whether Dani was bed sharing with the Martins at the time of her demise.

6. Other Issues

There were three other issues raised at the Inquiry that can be dealt with quickly.

There was discussion at the Inquiry as to whether the Graco brand travel crib the Martins used as Dani's crib was suitable but I find, on all of the evidence, that it was. Playpens are not appropriate places for infants to sleep presumably because they are not designed by the manufacturer for that purpose. On the evidence before me, Graco, a well-known supplier of infant products, marketed the travel crib as a crib and not a playpen. The Martins purchased the travel crib when S., an eighteen-month-old foster child at the time of Dani's death, was first taken into their care as a newborn. The Martins wanted S. to sleep in their bedroom, which is the preferred practice (see above), but a full-size crib would not fit. No concerns were raised by anyone as to the appropriateness of the Graco's use and I find on the evidence that it was discussed with Crossroads, the Martin's foster care agency, and approved for use in the Martin home. In any event, there is absolutely no evidence to show that the Graco crib was a potential contributing factor to Dani's death. It does not factor into any of the circumstances outlined above resulting in increased risk.

There was also evidence that Cheraty Martin placed a tightly rolled up towel behind Dani's back on the advice of a physician to reduce the risk that she would aspirate on spit up during the night by tilting her slightly in one direction while swaddled. Ms. Martin could not recall if the general practitioner or the pediatrician recommended this. This did not significantly run afoul of the practice of having an infant sleep supine in a bare crib. I would be very surprised to hear that it would have been recommended by a physician otherwise. There was also no policy requiring that Ms. Martin discuss following this doctor's recommendation with anyone prior to following it.

As I will discuss later in my report, the Martins were licensed to take in a maximum of four foster children at the relevant time. Counting Dani, they were caring for three. They also had two of their own children and were providing, on the night of Dani's death, respite care for four other children from another foster family. There were nine children in total in the Martin home the night Dani died. This was in accordance with relevant policies and licensing requirements. The presence of nine children in the house had no part to

play in Dani's death. More specifically, Cheraty Martin, who was primarily looking after Dani that night, was not prevented in any way by the presence of the other eight children, from providing appropriate care to Dani.

7. March 19 – April 9, 2013: Birth to Placement with Cheraty and Eric Martin

Dani was born on March 19, 2013 to her mother Kuna Sauvé and her father Paul Jean. She was full term and healthy at birth and weighed seven pounds and 15 ounces. There was nothing in the evidence before me to suggest that there were negative gestational influences.

At the time of Dani's birth, Ms. Sauvé had two other children from another father who were in the care of the Director appointed pursuant to the *Child Youth and Family Enhancement Act*.

For purposes, not relevant to this report, the Department of Human Services had well-founded concerns about Dani's safety if she remained with Ms. Sauvé and Mr. Jean. As a result, a temporary guardianship order was obtained on April 9, 2013 and Dani was apprehended. Ms. Sauvé and Mr. Jean cooperated in the apprehension process but it was very clear that they understandably found losing custody of Dani very difficult and painful.

8. April 9 – May 3, 2013: Placement to the Day before Dani's Death

Crossroads Family Services is and was contracted with Edmonton and Area Child and Family Services to provide foster placements within a catchment area that includes Edmonton. It was through Crossroads that Cheraty and Eric Martin were selected and asked to foster Dani until a permanent placement could be found. It was the intention from the time of her apprehension to have Dani placed with her aunt, Phoenix Boudreau in a kinship care arrangement. In accordance with Family Services' policy, formal criminal and security checks were required for Ms. Boudreau and her husband before kinship placement could be effected. This was entirely appropriate.

The Martins had been foster parents since 2004 and had cared for 27 foster children including four infants up to the time of the Inquiry. From the evidence at the Inquiry it is quite clear to me that you could not have found a family better suited to foster Dani than the Martins. They were both extremely diligent in following all of the requirements of the Department and Crossroads including keeping abreast of developments regarding safe sleeping practices. The Martins did not engage in the practice of bedsharing with infants in their home. Not only did they enthusiastically follow all of the training and guidelines for fostering, it is clear that they were role models for other foster parents and approached fostering as a calling and not as an occupation. They both clearly love children.

At the time Dani was taken into their care, the Martins had two of their biological children and two other foster children at home. The other children were ages 11, 9, 7 and 1 1/2 in April of 2013.

After her apprehension, Dani was turned over to Cheraty Martin at the Crossroads office at 2:30 PM on April 9, 2013. Ms. Martin testified that Dani was a beautiful baby but she was concerned about red spots present in the whites of her eyes and with the fact that her head was always leaning to the left.

After picking up some baby supplies, Ms. Martin took Dani home. She noticed that Dani was crying like she was in pain and would jolt and stiffen when being burped. She would not latch well onto the nipple of her bottle and would eat only one ounce or so of formula at a time. Ms. Martin continued to be concerned about Dani's head leaning to the left and about the red marks in her eyes.

Ms. Martin took Dani to the doctor on April 12. Dr. Michelle Craven was concerned about Dani's eating and also about the red marks in her eyes and referred her to a pediatrician, Dr. J. Brar. After examining Dani on April 15, Dr. Brar found that she was underweight and directed Ms. Martin to attempt feedings every four hours. An appointment was made for an ultrasound to look for brain bleeds as a result of the condition of Dani's eyes. In order to address her jolting and stiffening, Dr. Brar recommended that Dani be swaddled and it turned out that this was effective in calming her.

The ultrasound was expedited and took place on April 18. Thankfully, there were no brain bleeds detected.

On April 22, Ms. Martin took Dani to the pediatrician for a second time. Her eyes were getting better and by that time she was sleeping and eating better, too.

By the time Ms. Martin took Dani to Dr. Brar a week later, on April 29, she had gained 10 oz. and was no longer underweight. In fact, Ms. Martin gave evidence that Dani was starting to get chubby. The pediatrician indicated that they could now change the appointments to every two weeks from weekly in light of Dani's progress. Ms. Martin was elated when she relayed this good news to Rebecca Lima, her foster parent support worker at Crossroads. That same day Ms. Sauvé and Mr. Jean had a visit with their daughter.

Two days later, a cold was working its way through the Martin house[iv] and Ms. Martin noticed that Dani had redness on her bottom and some whiteness in her mouth. Although her own children had never suffered from thrush, Ms. Martin had seen it before and suspected that Dani had it.

9. May 3 and May 4, 2013

Ms. Martin took Dani to see Dr. Craven the morning of May 3 and thrush (Oral Candidiasis) was diagnosed. Thrush is a mild fungal infection sometimes affecting infants and adults with compromised immune symptoms. Dr. Craven prescribed Mycostatin antifungal oral suspension and cream for Dani's mouth and bottom respectively.[v]

Ms. Martin dropped Dani off for her regularly scheduled visit with Ms. Sauvé and Mr. Jean and then picked up the prescription and did some grocery shopping before picking her up again.

Ms. Martin and Dani arrived home at about 3:00 PM. Besides having their own children and foster children with them that day, the Martins were providing respite care for four children between the ages of 8 and 16 from another foster family. This was a regular event as the two families often spelled each other off. In fact, the children and foster children from the respective families called each other cousins. This arrangement was well known to Crossroads and was in compliance with all relevant policies. Ms. Martin described it as a sort of sleepover event.

The respite foster children were at the Martin's when Ms. Martin and Dani arrived home. Ms. Martin could not recall whether they were already present or whether she picked them up from the other foster family on her way home with Dani.

On arriving home, Ms. Martin gave Dani her thrush medicine and Dani spent the rest of the afternoon napping on and off. Dani was napping longer than normal and Ms. Martin kept trying to rouse her to attempt a feeding since she was not sure whether Dani ate anything during the visit with Ms. Sauvé and Mr. Jean earlier in the day.

Mr. Martin came home from work and took some of the older children to lacrosse for the evening. By the time they came from lacrosse all of the children who stayed at home except Dani were in bed and Ms. Martin was folding laundry. Ms. Martin checked to see if the returning children wanted a bedtime snack. They did not so they brushed their teeth and went to bed as well. Mr. Martin went into the master bedroom to lie down and watch TV. It was a Friday night and he had worked all day at his concrete cutting job before going to lacrosse in the evening so he would clearly have been fatigued. He fell asleep on top of the covers.

Ms. Martin was alone with Dani in the living room, also watching TV. She unswaddled Dani, blew down her back and gave her kisses to wake her up to feed. After Dani took a little bit of a bottle, she spit the nipple out. Ms. Martin then changed her diaper, swaddled her and put her to bed in the Graco crib on the left side of the master bed, directly beside where Ms. Martin slept. There were no other children in the master bedroom.

There was nothing in the crib except a firm mattress and the tightly rolled up towel propping Dani up a bit on one side from her supine position as recommended by the doctor in case Dani spit up during the night. After Dani went down, Ms. Martin woke Mr. Martin, who was still asleep on top of the covers, so that he could go to bed. Ms. Martin then went to bed herself and watched TV in the bedroom for some time because she thought it was possible that Dani would wake up hungry right away. At about 11:30 PM, Ms. Martin turned the TV off. Shortly after this she also fell asleep. She was expecting that Dani would probably get up at 3:00 AM at the latest ready to feed. That was Dani's normal pattern.

Ms. Martin woke up at 5:02 after hearing S., the 1 ½ year old child, making some noise right across the

hall. She noted the precise time from the alarm clock upon waking. She grabbed a bottle from the kitchen and gave it to S. and went straight back to bed. She was out of bed for about a minute since the bottle was pre-prepared and S. preferred cold milk so the bottle did not need to be heated.

She returned to the master bedroom, which was dark because there was tin foil on the windows to keep the sun out. Thinking that Dani would wake up any minute to be fed, Ms. Martin took her from her crib and brought her to the bed where Ms. Martin lay on top of the covers while she cradled Dani in her arm. Mr. Martin was still asleep beside her under the convers. Dani's position in the crib had not changed since she was put down. Ms. Martin also retrieved the bottle filled with formula she had placed in the crib earlier in preparation for feeding Dani.

Dani did not awaken when Ms. Martin retrieved her and Ms. Martin could not tell if she was warm to the touch since Dani was swaddled and Ms. Martin was wearing a long-sleeved top.

Ms. Martin propped herself up on the pillows in bed and cradled Dani for about ten minutes. During that time, Ms. Martin was "dozy" and closed her eyes but she did not fall asleep. Mr. Martin's cell phone alarm then went off at about 5:15 or 5:20 AM and he awoke for the first time, used the washroom, and returned to bed. The alarm was set for Mr. Martin's normal work day but it was Saturday and it was not necessary for him to get up.

S. then started to fuss again across the hall. Ms. Martin waited for a minute to see if he would settle himself. He did not so Ms. Martin slid Dani off her arm and put her, still swaddled, on the bed on top of the covers on Ms. Martin's side. She left the bedroom and waited in the hall to see what S. would do. In the meantime, she grabbed a quick snack, chocolate chips or a granola bar she thinks, from the hall closet which was a makeshift pantry. Once again, she was out of the bedroom for about a minute before returning.

I pause to note here that I do not consider what Ms. Martin described to be bed sharing. Bed sharing is referred to in the literature as taking the baby to bed with another person and sleeping there together. From the evidence of Dr. Bannach I conclude that from this practice comes the risk of suffocation due to overlaying and/or the presence of loose sheets, bedcovers and pillows which should be absent from an infant's bed. A conscious adult cradling a baby while propped up in bed is not bed sharing. There is always a risk that a sleepy adult will nod off in those circumstances but that can occur in a bed, a couch or an easy chair. In fact, there is some comment in the literature that falling asleep with an infant in a couch or an easy chair is a greater risk than nodding off with an infant in bed.[vi]

I also conclude that it was not unreasonable for Ms. Martin to put Dani, swaddled and overtop of the covers, on her bed while she checked on S. for less than a minute. It is true that Dani was left alone in an adult bed with a sleeping Mr. Martin but that is not bed sharing. The risk of suffocation comes, according to Dr. Bannach, when the baby is not breathing for four or five minutes. To comply with the absolute letter of safe sleep recommendations, Dani could have been put back in her crib but Ms. Martin, and all responsible mothers, live in the real world. She did not put Dani at risk by doing what she did.

When Ms. Martin returned to the bedroom she couldn't see Dani immediately. She was approaching the bed from Mr. Martin's side and he had shifted the covers off his feet while she was out of the room presumably blocking her view of Dani.

Ms. Martin then said "where is the baby" a couple of times and Mr. Martin awoke. He asked if Dani was in the living room, since that was the last place he had seen her. Ms. Martin checked briefly even though she knew it was not possible and returned to the bedroom. She also double checked the Graco. Mr. Martin then got up and noticed that the covers were heavy on one side. He found Dani on top of the covers, still swaddled. This was at approximately 5:30 AM.

When Mr. Martin passed Dani to Ms. Martin, Dani's arm fell out of the swaddling and Mr. Martin knew something was not right. He turned on the light and they both noticed that Dani looked greyish. Mr. Martin noticed that she was not breathing and immediately attempted CPR on the bed. That didn't work since it was too soft a surface so he took Dani to the floor, continued CPR and told Ms. Martin to call 911.

The 911 call was introduced in evidence. Ms. Martin was so distraught that she was not making much sense at all on the telephone. She was clearly overcome with emotion. In her own words, she was "freaking out". Mr. Martin maintained his composure and provided most of the required information to the

911 operator while Ms. Martin continued CPR.

By the time emergency services arrived he had taken Dani to the kitchen floor where he continued CPR.

The Edmonton Police Service ("EPS") were first on the scene at about 5:35 AM. Constables Hiller and Dodman were partnered on that shift and they had an Emergency Medical Technician ("EMT") ride-along, Chris Carson.

On arriving at the scene, Mr. Carson took over doing chest compressions and Cst. Dodman performed mouth to mouth resuscitation. While this was taking place, Cst. Hiller took the Martins aside and attempted to gather some information from them and to assist them in locating some records regarding Dani that the hospital might need.

Mathew Gates, a paramedic with Alberta Health Services ("AHS") was dispatched to the Martin's at 5:34 AM and his ambulance arrived at the house at 5:41. I note here that Mr. Gates acknowledged in his evidence that some of the times automatically entered into his report by his tablet appear to be off by one hour and he does not know why. I find that the times of dispatch and arrival are likely accurate since they mesh with the recollection of the Martins and the notes of the EPS members. Mr. Gates continued ventilation and started an intraosseous line[vii] but Dani did not revive and there were no signs of life.

Acting Sergeant De Zoeten and Constable Coates arrived at the Martin's just before the ambulance left.

The ambulance left the house at 5:49. Ms. Martin accompanied Dani to the hospital as did Cst. Dodman. The records the Martins and Cst. Hiller were looking for could not be found prior to the departure of the ambulance.

Mr. Gates noted in his report, prepared later during his shift, that the "baby was last seen awake at 03:00" but he could not recall from whom he received this information. I could have been from the parents or from the EPS members who were first on the scene.

After the ambulance left, Cst. Hiller continued to assist Mr. Martin in locating documentation about Dani for use at the hospital. Cst. Hiller then received word from his partner, Cst. Dodman, who left with the ambulance, that the hospital staff already had what they needed.

Cst. Hiller and Mr. Martin then went to the master bedroom and the events of the evening were reviewed. Cst. Hiller's evidence as to what Mr. Martin told him is consistent with Mr. Martin's recollection of events at this Inquiry. During this discussion in the bedroom, Mr. Martin noticed a yellow stain on the bedcovers that could have been either spit up or formula. I conclude that it was almost certainly formula that would have leaked out of the bottle. Dani was almost certainly already dead when Ms. Martin took her from the travel crib.

Cst. Dodman's notes as to the events of that evening indicate that Cst. Hiller told him the following from his (Cst. Hiller's) discussion on scene with Mr. Martin:

- Ms. Martin told Mr. Martin that Dani was fed at about 3:00 AM;
- Ms. Martin told Mr. Martin that Dani was then brought into bed to sleep with the Martins;
- Mr. Martin awoke at 5:00 to use the washroom and did not know that Dani was in the bed;
- Mr. Martin awoke again at 5:30 when Ms. Martin was frantically asking where Dani was;
- He noticed that the covers were heavy on one side and found Dani "wrapped in the sheets".

Cst. Hiller's testified that he might have radioed Cst. Dodman when Dodman was at the hospital and that he might have given him some details over the radio. Cst. Hiller had no recollection of telling Cst. Dodman the Dani was last seen alive at 3:00 AM. Cst. Hiller testified that he did **not** tell his partner that Dani was found "wrapped in the sheets" since that is inconsistent with the conversation he recalls having with Mr. Martin at the scene.

Acting Sgt. De Zoeten's notes indicate that Cst. Hiller was the member taking information from Mr. Martin. De Zoeten noticed that Ms. Martin was "frazzled", crying and that she was asking questions in "rapid fire". She kept going back and forth between the house and the ambulance without her shoes on, undecided as to whether or not she should go to the hospital with Dani.

Acting Sgt. De Zoeten's notes indicate that he heard Mr. Martin say that he as awakened by his wife having a "night terror" and asking where the baby was. Mr. Martin then said he felt a weight and found the baby "wrapped up on top of the comforter" and not breathing. De Zoeten's notes make no mention of 3:00 AM but it is not known whether he was present for the entire conversation with Mr. Martin.

The ambulance took Dani to the Grey Nuns hospital where she was seen by the ER staff and Dr. Cheniwchan. She was declared dead at 6:22 AM. There were no witnesses from the hospital but the records regarding Dani were put into evidence.

Ms. Martin did not recall talking to the ER doctor about the events of that night. The doctor's handwritten notes from Dani's chart indicate: "Lst seen alive at 0300". The nurse's emergency department record has the following phrase: "@0300 hrs mom found babe in blankets not breathing".

Of note, Mr. Gates, the EMT, and Cst. Dodman, the EPS member whose notes indicate that the baby was "wrapped in the sheets" were at the hospital. A copy of the notes prepared by Mr. Gates indicating the baby last being seen alive at 3:00 AM were on the hospital file.

10. Events After May 4, 2013

After Dani's death, Office of the Chief Medical Examiner ("OCME") was contacted. The initial Investigator's Report of Death, presumably prepared on the strength of the hospital records, has the following quote, "Child was previously fine. Baby was taken into foster parent's (*sic*) bed. Later foster mom woke and couldn't see the baby. She found the baby tangled up in the bedding." I conclude that the OCME investigators prepared this initial report before they interviewed the Martins. The interview with the Martins was on May 9, 2013.[viii]

In the "Baseline History and Scene Information for the Investigation of an Unexplained Infant Death", which was prepared following the interview with the Martins on May 9, there is no mention of Dani being found alive at 3:00 AM nor is there any mention of her being in the bedding. Rather, the details recorded from the Martins by the OCME investigators are entirely consistent with the testimony they gave at this Inquiry.

The Autopsy Report Form prepared by Dr. Bannach signed on October 16, 2013, indicates that Dani was taken to the foster parents' bed at 0300 and found dead at 05:30. He concludes that Dani was co-sleeping with adults which is unsafe and that overlaying (which can cause death by suffocation) cannot be ruled out. Dr. Bannach testified that he had all of the EMS, EPS and hospital records (referred to above) on his file and agreed that the 0300 (3 AM) reference is not present on the notes taken by the OCME investigators following the interview with the Martins. Dr. Bannach did not speak directly to the Martins.

The Martins were interviewed by the EPS on December 7, 2013. Once again, their interviews were entirely consistent with the evidence they gave at this Inquiry. They both maintained, as they always had, that Dani was not awake at 3:00 AM and that she was not found in the bedding, tangled or otherwise. No criminal charges were laid against anyone arising from this death and the police file was closed.

Alberta Human Services, Child and Family Services prepared a chronology based on information from the OCME records, information the crisis unit obtained from the emergency room physician and other unspecified records. The chronology, once again, indicates that Ms. Martin brought Dani to her bed at 3:00 AM and that Dani was later found "tangled up in the sheets". This information was corrected by the Martins on March 26, 2014 when they were given an opportunity to review the chronology. The Martins, once again, indicated that Dani was not brought to bed at 3:00 AM and was found swaddled on the bed, not tangled in the sheets.

In July of 2014 the Office of the Child and Youth Advocate published a report on this case, using pseudonyms, entitled "Baby Dawn: Bed-Sharing with Infants in Foster Care"[ix] The investigative team and the Advocate's office reviewed file information from Child Intervention Services and the EPS. A number of people, not all of whom are listed in the report, were interviewed. Relevant to the issue before me, the Child and Youth Advocate concluded that "[s]ometime through the night Carrie [Ms. Martin] brought Dawn [Dani] into the foster parents' bed. Recollections of the timing and events of the night are varied. But, at approximately 5:00 a.m. Dawn [Dani] was found not breathing and unresponsive in the foster parents' bed."

The Report describes at length the steps that have been taken in Alberta and Canada to research and address safe sleeping practices, including bed-sharing. This work has culminated in the publication of the following documents:

a. A memo dated November 23, 2011 from the Director of the Child, Youth and Family Enhancement Act Director to all Child Intervention Services Area outlining the dangers of bed-sharing.
b. The placing of links on the Child, Youth and Family Enhancement Manual on safe sleep resources from Alberta and Canada, copies of which were introduced in evidence at this Inquiry.
c. The requirement that foster parents take a two-day training program, implemented in 2014, entitled "Safe Babies Caregiver Education Program" which contains a module on safe sleeping practices. This was also referenced at this Inquiry.

The Child and Youth Advocate, in the "Baby Dawn" report made one recommendation; that the "Ministry of Human Services should implement clear policy for foster parents providing direction not to bed-share with infants placed in their care."

This recommendation was accepted by the Ministry and implemented. [x]

11. The Martins Were Not Bed Sharing

Two statements, or variants of them, are repeated again and again in the various reports entered in evidence at this Inquiry: That Dani was taken into the Martin's bed at 3:00 AM and that Dani was found in, wrapped in, or tangled in the covers or sheets. Both of these statements gave rise to conclusions or suspicions of bed sharing. There was absolutely no first hand evidence of supporting either of these two statements at this Inquiry. They are present only in the paper exhibits entered in this case.

This Inquiry highlights, in vivid colour, the danger of relying on hearsay evidence that cannot be shown circumstantially to be reliable. Rules of evidence at a Public Fatality Inquiry are more relaxed than at a criminal trial but the principles underlying those rules exist for good reason and are applicable in the evidence weighing process here. As I will describe, not only is there no indication of circumstantial reliability supporting the hearsay evidence in this case, circumstances exist which amplify its unreliability. There is even one example of hearsay evidence in this case that is dead wrong by any measure. This is not to cast blame on the people who recorded this information. They were all trying their best, I am convinced, to perform their respective roles. People may be familiar with the telephone game where a phrase is whispered in one ear and repeated along a line of people, all trying their best to repeat what they heard, until a phrase bearing little relation to what was initially said emerges at the far end. There are shades of the telephone game in this case.

Against this unreliable second, third and fourth hand evidence I have the sworn testimony of Cheraty Martin and Eric Martin, both of whom are, and this is critical, the only people who can give a first-hand account of what happened with Dani on May 4, 2013. They were both excellent witnesses and tried their level best to give an accurate account of the events of that awful night.

I will now follow, in some detail, the path of those two phrases down the line of players in this case.

Cst. Hiller, Cst. Dodman and Chris Carson were the first on the scene after Ms. Martin called 911. Chris Carson does not figure into the analysis since he was entirely occupied providing CPR to Dani and did not make a report. Cst. Dodman was also involved in CPR and, within minutes, accompanied the ambulance to the hospital with Ms. Martin.

Cst. Hiller was the EPS member tasked with obtaining information from the Martins. He has no recollection of anyone telling him that Dani was seen at 3:00 AM nor does his report contain any mention of this. He does recall, after the ambulance left, going to the bedroom with Mr. Martin and being told and shown that Mr. Martin found Dani after Mr. Martin noted there was a weight on the blankets beside him. This shows, of course, that Dani was on top of the covers, not in or under them. Cst. Hiller's report notes that Dani was found between the Martins "among the blanket" (*sic)*. This was after Mr. Martin arose and Dani's position was disturbed.

Acting Sgt. De Zoeten witnessed at least some of the conversation between Mr. Martin and Cst. Hiller and noted that Mr. Martin noticed the weight on the blankets and found Dani "wrapped up on top of the comforter". It is clear to me that the "wrapped up" noted by Cst. De Zoeten describes finding Dani

swaddled but on top of the comforter, exactly as described by the Martins at this Inquiry. It is entirely likely that confusion started right here and that describing Dani in his notes as being "wrapped up" was interpreted by others as meaning wrapped up in the bedclothes not properly swaddled in her receiving blanket. I note again that De Zoeten's notes make no mention of 3:00 AM.

Cst. Dodman's notes indicate that he was told by Cst. Hiller that Ms. Martin told Mr. Martin that Dani was fed at about 3:00 AM and then brought to bed with the Martins. Cst. Dodman's notes also indicate that Cst. Hiller told him the covers were heavy on one side and Dani was found "wrapped in the sheets". This is likely a misinterpretation of what he may have been told of the swaddling. It is certainly not what Cst. Hiller and Acting Sgt. De Zoeten heard from Mr. Martin. The "wrapped up" narrative was already becoming distorted.

Cst. Hiller has no recollection of telling Cst. Dodman anything about 3:00 AM and it is not reflected in his notes or in the notes of Acting Sgt. De Zoeten. So where did that come from? It is important to note that, with respect to this issue, we are already considering triple hearsay. Cst. Dodman's notes indicate that this was information given by Ms. Martin to Mr. Martin to Cst. Hiller to him.

I pause here to remind myself that the original source of this information, before it went through three hands, would have been Ms. Martin, after she woke Mr. Martin from a dead sleep and where she was virtually incoherent and in a state of absolute panic as evidenced by the 911 recording. She was in no condition to give accurate information to anyone about anything at that stage.

Mathew Gates could not recall the source of his notation that the baby was last seen awake at 3:00 AM. It could have come from the Martins or the EPS who were first on the scene. I expect he could have received it from Cst. Dodman since the two of them went to the hospital together in the ambulance but, in the end, it doesn't matter.

It is entirely possible that Ms. Martin, in her "rapid fire" monologue uttered something about expecting Dani to be awake for her 3:00 AM feeding since she did have that on her mind on May 3 before retiring. This could have been interpreted by Cst. Hiller or Mr. Gates as Dani being fed at 3:00 AM. We will never know for certain but what I do know for certain is that the 3:00 AM reference in Cst. Dodman's notes and Mr. Gates report is unreliable.

From here I turn to the hospital records. Ms. Martin has no recollection of speaking with the hospital staff but Cst. Dodman and Mr. Gates were both at the hospital and Mr. Gates' notes are copied in the hospital file. These are potential sources of notations on the hospital records.

Dr. Cheniwchan's handwritten notation referring to Dani last being seen alive at 3:00 AM is now at least quadruple hearsay and is less reliable than the already unreliable EPS or EMS notes upon which it was undoubtedly based. The nurse's notes on the hospital file say "@0300 hrs mom found babe in blankets not breathing". What started as a notation from any unreliable source that the baby was alive at 3:00 AM morphed after passing through a number of hands into a statement that the baby was found **dead** at 3:00 AM.

These many unreliable and erroneous notations were on the OCME file and undoubtedly led Dr. Bannach to conclude that Dani was co-sleeping with adults.

The Child and Family Services chronology based on the same documentation and now potentially five or six links down the chain, reference Dani being brought to bed at 3:00 AM and found "tangled up in the sheets". A child swaddled in a receiving blanket was noted as being "wrapped up" and later noted as "wrapped up in the sheets" and now "tangled up in the sheets".

Anyone reading the voluminous set of documents prepared in this case with these many many references would be moved to conclude that this was a clear case of bed sharing with adults. But just as all roads lead to Rome, all references to 3:00 AM and Dani being wrapped up lead back to a misinterpretation of what the Martins said or may have said in a scene of utter chaos. Those misinterpretations are further distorted as the message is passed along.

I do not know what information was reviewed by the Office of the Child and Youth Advocate but I do not conclude following this Inquiry that "[r]ecollections of the timing and events of the night are varied" insofar as they relate to the issue of bed sharing. I conclude, rather, that recollections of what people were **told**

about the timing and events of the night are varied. This is, of course, the inherent danger when a narrative is passed down from one person to the next and the next. Recollections of what actually **happened** that night, coming from the only two first hand witnesses, Mr. and Ms. Martin, are clear and have never varied. The Martins gave the same information to the EPS, the OCME investigators, Child and Family Services, and finally to me, under oath.

12. Recommendations for the prevention of similar deaths

It is laudable that, since Dani's death, many steps have been taken to address the safe sleep issue for children in foster care. None of these changes would have prevented Dani's death, however, since the Martin's were following safe sleep practices on May 3 and 4, 2013 even by today's standards.

Even in the 21st century, infants inexplicably die despite the best of care being provided to them. That is, tragically, what happened to Dani.

Therefore, I make no recommendations in this case.

Given that I have not been able to determine a cause or manner of death and given that I have made no recommendations, what has been accomplished at this Public Fatality Inquiry?

At the conclusion of the evidence, Dani's mother, Ms. Sauvé, who was present and participated during the Inquiry's entire course, was asked if she had any submissions to make. She did not but she took the opportunity to state publicly that the Martins took good care of Dani. Nothing will ease the pain felt by Ms. Sauvé, Mr. Jean or the Martins following the death of baby Dani and nothing will restore the loss of all Dani would have contributed to the world. But, to me, this unselfish statement made by Ms. Sauvé following her hearing of all of the evidence made the holding of the Inquiry entirely worthwhile.

DATED April 6, 2017,

at Edmonton, Alberta.

Original signed by

Greg Lepp
A Judge of the Provincial Court of Alberta

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[i] Case Summary of the Fatality Review Board dated January 10, 2014.

[ii] *Sudden Infant Death Syndrome in Canada*: *Trends in rates and risk factors.* *http://www.phac-aspc.gc.ca/publicat/hpcdp-pspmc/25-1/a-eng.php; http://www.mayoclinic.org/diseases-conditions/sudden-infant-death-syndrome/basics/causes/con-20020269*

[iii] This is likely the single most significant risk factor. Since the implementation of the "Back to Sleep" program, now known as the "Safe to Sleep" program in the US, the rate of unexplained deaths of infants has fallen dramatically. See https://www.nichd.nih.gov/sts/about/SIDS/Pages/progress.aspx. Rates have also dropped dramatically in Canada – see endnote ii.

[iv] It is possible that Dani had a cold at the time of her death but this risk factor was unavoidable.

[v] Dr. Bannach testified that the presence of thrush would not have contributed to Dani's death.

[vi] http://www.npr.org/sections/health-shots/2016/10/25/499290404/new-guidelines-acknowledge-the-reality-babies-do-sleep-in-moms-bed. This is because of the risk that the child will fall into the crevices in those pieces of furniture.

[vii] An interosseous line is used on infants instead of an intravenous line. The fluid is introduced into the bone rather than the patient's vein.

[viii] Although the report is undated, the interview with the Martins took place on May 9, 2013 and a toxicology request, containing exactly the same phrase appearing in the Investigator's Report of Death, was printed on May 6, 2013, three days before the interview with the Martins

[ix] http://www.ocya.alberta.ca/wp-content/uploads/2014/08/InvRev_Baby-Dawn_2014August.pdf
[x] http://www.humanservices.alberta.ca/documents/response-to-ocya-report-dawn.pdf